

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Clearbrook West# 0033035 Report Period Beginning: 7/1/00 Ending: 6/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,364</u>			<u>5,364</u>	13
14	TOTALS	<u>5,364</u>			<u>5,364</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.85%

D. How many bed-hold days during this year were paid by Public Aid?

476 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/89

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date 01/01/89 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 07/01/00 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Clearbrook West

0033035

Report Period Beginning: 7/1/00

Ending: 6/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	20,211			20,211		20,211		20,211			1
2	Food Purchase		44,995		44,995		44,995		44,995			2
3	Housekeeping		8,901		8,901		8,901		8,901			3
4	Laundry											4
5	Heat and Other Utilities			14,528	14,528		14,528		14,528			5
6	Maintenance	17,158	3,234	24,469	44,861		44,861	3,215	48,076			6
7	Other (specify):*											7
8	TOTAL General Services	37,369	57,130	38,997	133,496		133,496	3,215	136,711			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	280,830	1,593		282,423		282,423		282,423			10
10a	Therapy											10a
11	Activities		1,735		1,735		1,735		1,735			11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation			1,836	1,836		1,836		1,836			14
15	Other (specify):* Program consultants			90,157	90,157		90,157		90,157			15
16	TOTAL Health Care and Programs	280,830	3,328	91,993	376,151		376,151		376,151			16
	C. General Administration											
17	Administrative	27,029			27,029		27,029	30,655	57,684			17
18	Directors Fees											18
19	Professional Services							1,697	1,697			19
20	Dues, Fees, Subscriptions & Promotions			267	267		267	1,282	1,549			20
21	Clerical & General Office Expenses		462		462		462	9,835	10,297			21
22	Employee Benefits & Payroll Taxes			58,357	58,357		58,357	4,724	63,081			22
23	Inservice Training & Education							3,034	3,034			23
24	Travel and Seminar			1,271	1,271		1,271		1,271			24
25	Other Admin. Staff Transportation							137	137			25
26	Insurance-Prop.Liab.Malpractice			6,630	6,630		6,630	344	6,974			26
27	Other (specify):* See page 24			8,964	8,964		8,964		8,964			27
28	TOTAL General Administration	27,029	462	75,489	102,980		102,980	51,708	154,688			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	345,228	60,920	206,479	612,627		612,627	54,923	667,550			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Clearbrook West

#0033035

Report Period Beginning:

7/1/00

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6/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			26,117	26,117		26,117		26,117			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,820	43,820		43,820	2,266	46,086			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			69,937	69,937		69,937	2,266	72,203			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,600	36,600		36,600		36,600			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			36,600	36,600		36,600		36,600			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	345,228	60,920	313,016	719,164		719,164	57,189	776,353			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Clearbrook West

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Clearbrook West

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

0033035

Report Period Beginning:

7/1/00

Ending:

6/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

6/30/01

6/30/01

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	0	Clearbrook Lattof Commons	Rolling Meadows	Clearbrook	Rolling Meadows	Not for profit
None	0	Clearbrook West	Rolling Meadows	CRH Inc.	Rolling Meadows	Not for profit
None	0	Clearbrook East	Rolling Meadows	Clearbrook	Rolling Meadows	Not for profit
None	0	Wright Home	Gurnee	Augustana	Gurnee	Not for profit

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Clearbrook West# 0033035

Report Period Beginning:

7/1/00

Ending:

6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Salaries	10,385,419	\$ 96,713	\$	345,228	\$ 3,215	1
2	17	Administrative	Salaries	10,385,419	922,189	922,189	345,228	30,655	2
3	19	Professional services	Salaries	10,385,419	51,043		345,228	1,697	3
4	20	Fees, subscriptions, and dues	Salaries	10,385,419	38,565		345,228	1,282	4
5	21	Clerical and general	Salaries	10,385,419	295,861		345,228	9,835	5
6	22	Employee benefits + taxes	Salaries	10,385,419	142,103		345,228	4,724	6
7	23	In service training and education	Salaries	10,385,419	91,278		345,228	3,034	7
8	25	Other admin transportation	Salaries	10,385,419	4,118		345,228	137	8
9	26	Insurance	Salaries	10,385,419	10,347		345,228	344	9
10	32	Interest	Salaries	10,385,419	68,166		345,228	2,266	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,720,383	\$ 922,189		\$ 57,189	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	HUD		X	Construct building	\$3,839.00	01/01/89	\$ 497,600	\$ 468,300	11/01/28	9.0000	\$ 42,331	1	
2	Harris Bank		X	Vehicle	\$692.74	04/01/98	33,193	13,470	04/01/04	8.6500	1,489	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$4,531.74		\$ 530,793	\$ 481,770			\$ 43,820	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 530,793	\$ 481,770			\$ 43,820	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Clearbrook West**# **0033035** Report Period Beginning: **7/1/00** Ending: **6/30/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2000 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	8		
	1997	9		
	1998	10		
	1999	11		
	2000	12		
			FOR OHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clearbrook West COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033035

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 5,216

B. General Construction Type:
 Exterior
 Aluminum
 Frame
 Wood
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building	36,839	1986	\$ 87,000	1
2					2
3	TOTALS	36,839		\$ 87,000	3

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1989	1989	\$ 495,998	\$ 13,302	40	\$ 13,302	\$	\$ 156,803	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler System		1989		7,797	211	37	211		2,423	9
10	Sprinkler System		1990		1,729	47	37	47		538	10
11	Protective wall covering		1993		2,480	71	35	71		602	11
12	Garage addition		1994		5,740	161	34	161		1,266	12
13	Bathroom remodeling		1998		7,726	818	10	818		2,409	13
14	Carpet		1996		4,876	488	10	488		2,682	14
15	Roof		2000		9,240	616	15	616		924	15
16	Fairfax kitchen remodeling		2000		10,717	429	25	429		643	16
17	Fairfax bathroom improvements		1999		9,043	624	15	624		1,247	17
18	Fairfax bathroom improvements		2000		2,319	155	15	155		232	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 557,665	\$ 16,921		\$ 16,921	\$	\$ 169,769	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 17,021	\$ 1,329	\$ 1,329	\$	7	\$ 10,006	71
72	Current Year Purchases	3,517	1,230	1,230				72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 20,538	\$ 2,559	\$ 2,559	\$		\$ 10,006	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient care	1997 Dodge Braun	1997	\$ 33,643	\$ 5,607	\$ 5,607	\$	6	\$ 19,625	76
77	Patient care	1997 Dodge Maxivan	2001	6,178	1,030	1,030		3	1,030	77
78										78
79										79
80	TOTALS			\$ 39,821	\$ 6,637	\$ 6,637	\$		\$ 20,655	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 705,024	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,117	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,117	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 200,429	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>44</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language Development Therapist		hrs								2
2	Licensed Recreational Therapist		hrs								3
3	Licensed Physical Therapist		hrs								4
4	Physician Care		visits								5
5	Dental Care		visits								6
6	Work Related Program		hrs								7
7	Habilitation		hrs								8
8			# of prescrpts								9
9	Pharmacy										
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
10	Academic Education		hrs								11
11	Exceptional Care Program										12
12											
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	330,314	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		2,860,173	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		84,582	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		102,915	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from temporarily restricted</u>		269,898	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	3,647,882	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		1,623,703	11
12	Long-Term Investments			12
13	Land		1,875,317	13
14	Buildings, at Historical Cost		14,445,685	14
15	Leasehold Improvements, at Historical Cost		201,032	15
16	Equipment, at Historical Cost		3,355,179	16
17	Accumulated Depreciation (book methods)		(5,126,316)	17
18	Deferred Charges		233,230	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Pre-paid rent</u>)		482,727	22
23	Other(specify): <u>Deposits</u>		119,632	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	17,210,189	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	20,858,071	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	478,643	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		952,882	29
30	Accrued Salaries Payable		1,183,864	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,623	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See page 25</u>		397,899	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	3,026,911	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,001,456	40
41	Bonds Payable		3,600,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to permanently restricted</u>		473,880	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	8,075,336	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	11,102,247	46
47	TOTAL EQUITY (page 18, line 24)	\$	9,755,824	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	20,858,071	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):	7,329,751	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,329,751	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	40,404	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Clearbrook net income net of Fairfax	2,385,669	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,426,073	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,755,824	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 653,961	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 653,961	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	97,238	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 97,238	23
	D. Non-Operating Revenue		
24	Contributions	7,340	24
25	Interest and Other Investment Income***	1,029	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,369	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 759,568	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	133,496	31
32	Health Care	376,151	32
33	General Administration	102,980	33
	B. Capital Expense		
34	Ownership	69,937	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	36,600	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 719,164	40
41	Income before Income Taxes (line 30 minus line 40)**	40,404	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 40,404	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Consolidated with our other programs

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Clearbrook West# 0033035Report Period Beginning: 7/1/00Ending: 6/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11	11	219	20.86	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,019	2,171	20,211	9.31	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,097	1,180	17,158	14.54	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	436	469	15,807	33.70	20
21	Assistant Administrator					21
22	Other Administrative	507	545	13,081	24.00	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,079	2,235	27,308	12.22	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	24,622	26,476	244,903	9.25	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Coordinator</u>	394	424	6,542	15.43	33
34	TOTAL (lines 1 - 33)	31,165	33,511	\$ 345,229 *	\$ 10.30	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$	See Clinic	35
36	Medical Director			Schedule	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	456	13,825		40
41	Occupational Therapy Consultant	364	9,105		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	465	17,205		43
44	Activity Consultant				44
45	Social Service Consultant	10	13,124		45
46	Other(specify) <u>Psychiatric</u>	10	19,065		46
47	<u>Medical Doctor</u>		24,000		47
48	<u>Neurological + Behavioral</u>	27	6,758		48
49	TOTAL (lines 35 - 48)	1,332	\$ 103,082		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Clearbrook West

STATE OF ILLINOIS

0033035

Report Period Beginning:

7/1/00

Ending:

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6/30/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 335 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 36,600
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Blackman Kallick Bartelstein The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Schedule V Line 6 Maintenance other

Communications	8,983
Postage & Shipping	85
FF&E repairs and maintenance	3,295
Vehicle repairs and maintenance	1,367
Care of building and grounds	7,152
Trash removal	2,482
Miscellaneous rent	1,105
	<u>24,469</u>

Schedule V Line 15 Other

Total clinic costs	
Consultants (see schedule VIII B Consultant Service)	103,082
Salaries/wages	398,874
Other Clinic costs	<u>209,873</u>
	711,829
Less allocation to CILA clients	<u>(42,784)</u>
	<u>669,045</u>

Allocation based on total clients served

Clearbrook Commons	92	496,388
Clearbrook East	16	86,328
Clearbrook West	16	86,328
	<u>124</u>	<u>669,044</u>

Clinic	86,328
Drugs	600
Nursing	51
Denistry	500
Vision	0
Dietician	2,253
Other medical	425
	<u>90,157</u>

Schedule V Line 27 Other

Specific assistance to individuals	303
Gas & Oil	1,331
(Gain) loss on sale of assets	1,092
Audit fees	3,750
Staff educational grants	485
Moving and recruiting	1,689
Staff medical exams	270
Bank and brokerage fees	0
Miscellaneous	44
	<u>8,964</u>

Schedule VIII Line 3 Professional services

Audit fees	25,555
Legal fees	14,307
Computer consulting fees	5,623
Temporary help	2,525
Accreditation	650
Administrative consulting	2,383
	<u>51,043</u>

Schedule VIII Line 7 Inservice training

Professional staff conferences	35,078
Board and committee meetings	4,164
Staff appreciation	17,678
Tuition assistance	33,889
Staff conferences and training	469
	<u>91,279</u>

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Reconciliation of cost reports to audit

Cost reports

Clearbrook East	791,943
Clearbrook West	719,164
Clearbrook Center	4,438,067
Augustana Group Home	999,306
	<u>6,948,480</u>
Less provider tax included in revenue in audit	<u>(362,584)</u>
	<u><u>6,585,896</u></u>

Audit

ICF			6,022,284
Subtract expenses related to special grant money			(20,606)
Expenses related to the \$1 and hour			(91,155)
Intercompany transactions			6,328
Clinic net of allocation to CILA	711,829	-42784	669,045
			<u><u>6,585,896</u></u>

Schedule XV Balance Sheet/Schedule of changes in equity

These statements are prepared on a consolidated basis on the Unrestricted Fund per the audit. We do not maintain separate balance sheets per program.

Schedule XV Balance Sheet Other current liabilities

Deferred revenue	83,508
Due to related parties	60,000
Due to government agencies	137,476
Other liabilities	7,689
Other accrued expenses	109,226
	<u><u>397,899</u></u>

Schedule V Line 15 Clinic salaries

BELL,PATRICIA	Behavior	30,997
CAMPUZANO,HELEN M	Speech	16,971
DEVITO, BRENDA	Program director	10,233
GRUENFELD, ROBIN	Habilitative aide	21,863
HANSEN, ROBERTA	Speech	49,577
LEW, LISA	Program director	25,000
MARTIN, TRACY	Admission director	9,395
MORGAN, ALICE	Secretary	12,000
MURRAY,CAROL	Speech	50,755
PETERSON, AMY	Habilitative aide	17,195
SCHREINER, LAURA	Clerical	31,000
SHEEHAN,KIM	Physical therapy	17,020
VANPUYMBROUCK, LAURA	Physical therapist	33,137
WRONKE,KATHLEEN	Physical therapy	45,136
		<u>370,279</u>
	Allocated elsewhere	<u>-2,560</u>
		<u><u>367,719</u></u>

Schedule VIII Line 2 Administrative Salaries

NAME	TITLE	SALARY
ANDERSEN,BERNADETTE	ADMINISTRATIVE ASSISTANT	42,136
APPLETON,KATHLEEN	VICE PRESIDENT-FINANCE	101,882
BAEZ-LOPEZ,ROSA	VICE PRESIDENT-HUMAN RESOURCI	68,918
BELLOMO,STACEY A.	PROGRAM COORDINATOR	58,446
CALDERON,TANIA	ADMINISTRATIVE ASSISTANT	30,519
CHEN, KENNETH	DATA ADMINISTRATOR	23,065
CIESKO, MARY	DATABASE SPECIALIST	14,969
COPELAND,ELIZABETH	RECEPTIONIST	17,233
FRICK,DONALD LEE	MIS	66,432
JOHNSON,ROBIN	PURCHASING DEPT	17,416
KAUFMAN,JOYCE	CLERICAL-HR	35,640
KORIL,SHERRY	ACCOUNTS RECEIVABLE SPECIALIS	31,969
LA-MELL,CARL	PRESIDENT	158,085
LOMBARDI,ANITA N	PAYROLL	40,818
MCCRADY, AIDRIENNE	DIRECTOR-HUMAN RESOURCES	49,827
MONASTERO, KATHY	PURCHASING DEPT	21,729
ROBINSON,DENISE	ADMINISTRATIVE ASSISTANT	29,505
PAULS,LESLIE	STAFF ACCOUNTANT	36,988
TALAGA,ROSEMARY	ACCOUNTS PAYABLE SPECIALIST	27,226
TURI,JAMES A	VICE PRESIDENT-BUS OPERATIONS	91,522
		<u><u>922,189</u></u>

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